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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SUSAN MARIE MCDOUGALL a.k.a. SUSAN MARIE MICHELBACHER** 563 Bakeman Lane Arroyo Grande, CA 93420 Registered Nurse License No. RN 565591 Respondent.	Case No. 2011-67 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 24, 2000, the Board of Registered Nursing issued Registered Nurse License Number RN 565591 to Susan Marie McDougall a.k.a. Susan Marie Michelbacher (Respondent McDougall). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

8. Section 2725 of the Code states:

"(a) In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures that have

common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems that provide for collaboration between physicians and registered nurses. These organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services.

"(b) The practice of nursing within the meaning of this chapter [the Nursing Practice Act] means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:

(1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

(2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

(3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

(4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

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9. Section 118, subdivision (b), of the Code provides that the suspension/expiration/surrender/cancellation of a license shall not deprive the Board/Registrar/Director of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

REGULATIONS

10. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

11. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

12. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

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"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

DEFINITIONS

13. **Ativan** - is the trade or brand name of Lorazepam. It is a Schedule IV, controlled substance, pursuant to Health and Safety Code Section 11057(d)(16) and is a dangerous drug pursuant to Business and Professional Code, Section 4022.

14. **Morphine/Morphine Sulfate** - is a Schedule II, controlled substance, pursuant to the CA Health and Safety Code Section 11055(b)(1)(M) and a dangerous drug pursuant to the Business and Professions Code 4022. MS Cotin, Msir, Oramorph SR and Kadian are brand names for Morphine sulfate.

15. "**Pyxis**" is a computerized automated medication system which operates similarly to an automated teller machine at a bank. Mediations can be withdrawn from the Pyxis machines only by an authorized staff person using his or her own personalized access code. The Pyxis machine makes a record of the medication and dose, date and time it was withdrawn, the user identification, and the patient for whom it was withdrawn.

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FACTS COMMON TO ALL CAUSES FOR DISCIPLINE

16. The following facts are common to all causes for discipline in this matter:

A. At all times relevant herein, Respondent Susan Marie McDougall was employed as a registered nurse in the Sierra Vista Regional Medical Center in San Luis Obispo, California (Medical Center). On February 3 and 4, 2009, she was assigned to work in the surgical recovery room.

B. At all times relevant herein, Diana Dean Stevens was employed as a registered nurse in the Intensive Care Unit (ICU) of Sierra Vista Regional Medical Center in San Luis Obispo, California (Medical Center).

C. Patient Ruben N. (Patient) a 26 year old disabled resident of a skilled nursing facility, suffered respiratory and cardiac arrest on January 29, 2006. He was taken in a coma to Medical Center.

D. At Medical Center, he was diagnosed as having suffered irreversible brain damage, and was maintained on a respirator.

E. According to Medical Center records, Patient weighed 80 pounds at the time of his admission.

F. Physician's Orders:

1) Morphine. On February 1, 2006, Dr. Shultz wrote an order for Morphine, for severe pain, every 15 min IV.

2) Ativan. On February 1, 2006, Dr. Ryan wrote an order for Ativan, 2mg every 15 minutes, PRN for seizures. On February 3, 2006, Dr. Ryan wrote a second order for Ativan, 10 mg every 4 hours for lip smacking.

G. On or about February 2, 2006, Patient's mother gave consent for donation of his organs for transplant after cardiac death, to California Transplant Donor Network (CTDN).

H. On or about February 3, 2006, Dr. Hootan Roozrokh traveled by air to Medical Center with a team from CTDN to procure Patient's organs for transplant. He arrived at approximately, 2210 hours.

I Carla Albright, RN, was an organ harvest team coordinator from CTDN.

J. On or prior to February 2006, CTDN had provided an in- service training for Medical Center Staff regarding organ recovery. Stevens did not attend the training, though she received and reviewed a pamphlet and/or training handouts placed in her hospital mail box.

K. On February 3, 2006 at the beginning of her regular shift, at approximately 1900 hours, Stevens was assigned as the primary nurse to care for Patient by the ICU charge nurse. He was the only patient assigned to her that evening.

L. The following events then transpired in ICU:

TIME	FEBRUARY 3, 2006
1930 hours	Stevens assessed Patient's neurological status and documented her assessment. (24 Hour Critical Care Flow Sheet).
Prior to 2132 hours	Carla Albright (organ harvest team coordinator) met with Stevens in the ICU near the beginning of her shift. Albright then requested that Stevens give Patient Morphine and Ativan. Stevens then administered both drugs twice, as detailed below, in compliance with Albright's request.
2132-2154 hours	Per the ICU Pyxis report, the following medications were removed by Stevens for Patient from the ICU Pyxis: 10mg Morphine (at 2132 hours) 2mg Ativan (at 2132 hours) 2mg Ativan (at 2153 hours) 10 mg Morphine (at 2154 hours)
2205 hours	**Administration of Medication :** Stevens administered (per Physician's Orders) 10 mg Morphine, and 2 mg Ativan. - Stevens noted lip movement and focal seizures in connection with the administration of Ativan. (24 Hour Critical Care Flow Sheet). - However, Stevens observed no evidence that Patient was in severe pain.
e) prior to 2230 hours (estimated)	Dr. Roozrokh, accompanied by Dr. Martinez arrived at ICU, and reviewed Patient's chart.
2230 hours	**Administration of Medication:** Twenty-five minutes after administering 10 mg Morphine, and 2 mg Ativan; Stevens administered both drugs a second time. - Stevens did not recall observing any evidence of seizures

	in connection with the second administration of Ativan. - Stevens did not observe evidence that Patient was in severe pain.
2300 hours (estimated)	Dr. Roozrokh then ordered 100 mg of Morphine and 40 mg of Ativan for Patient. He wrote and signed the Physician's Order in Stevens' presence.
2307-2311 hours	Per Pyxis records, the following medications were removed by Stevens for Patient from the ICU Pyxis: 40 mg of Morphine (at 2307 hours), 60 mg of Morphine (at 2308 hours), 4 mg of Ativan (at 2310 hours), 20 mg of Ativan (at 2310 hours) 16 mg of Ativan (at 2311 hours) Stevens stored the medications in her pocket, pending Patient's move to the operating room.

M. Shortly before midnight (at approximately 23:10), Patient was transported to the Operating Room (OR). Stevens was instructed by the ICU charge nurse to accompany Patient to the OR in order to administer medication obtained from Pyxis. It took approximately 5-6 minutes to push Patient's bed from the ICU to the OR. Stevens did not observe evidence that Patient was in pain or any sign of anxiety during transport.

N. Carla Albright instructed Stevens to change into surgical scrubs, and she did so.

O. Carla Albright requested that Stevens give her (Albright) 2 of the vials of Morphine (20 mg) that she had brought from ICU and she did so.

P. After scrubbing and gowning, Stevens entered the OR. She observed that Albright, Dr, Martinez and Dr. Roozrokh, among others, were present in the room, and that Dr. Roozrooh was removing what Stevens thought was a gastric tube from Patient.

Q. Dr. Lubarsky, who was on-call for Patient's attending physician at Medical Center, arrived about 15 minutes after Stevens entered the OR.

R. The following events then transpired in the OR. Throughout these events, Stevens was physically positioned, in relation to other personnel and the Patient, so that she was unable to clearly observe the patient or see his electronic monitors:

TIME	February 4, 2006
1) 0007 hours (estimated)	**Administration of Medication:** Stevens was ordered by Carla Albright to give Patient "half of what you have." Stevens then administered to patient 50 mg of Morphine and 20 mg of Ativan intravenously. (Medication administration was not charted) Dr. Lubarsky then ordered the removal of the breathing tube and the tube was removed. Patient continued breathing on his own after the breathing tube was removed. Stevens observed no indications that Patient was in pain, anxious or having seizures.
2) 0017- 0020 hours (estimated)	10- 15 minutes after the breathing tube was removed, Patient was still breathing, and had a sinus rhythm (heartbeat). Dr. Roozrokh stated that he didn't feel a pulse and wanted to call a P.E.A. (Pulseless Electrical Activity.) Dr. Lubarsky examined Patient and reported that she felt a pulse.
3) 0017 – 0020 hours (estimated)	**Administration of Medication:** Dr. Roozrokh ordered Stevens to give the remainder of the Morphine (30 mg) and Ativan (20 mg) to Patient. Stevens did so. (Medication Administration was not charted) Stevens observed no indications that Patient was in pain, anxious or having seizures.
4) prior to 0020 hours	Roozrokh requested (verbally) that Stevens obtain the same amount of medicine he had ordered before. She then phoned the Medical Center nursing supervisor, and requested 100 mg of Morphine and 40 mg of Ativan. The supervisor delegated Respondent Susan McDougall to bring the medications to the OR.
5) 0020-0026 hours	Per Medical Center Pyxis records, the following medications were removed by Respondent McDougall from various Pyxis machines: 10 mg of Morphine (at 0020 hours) 16 mg of Ativan (at 0020 hours) 90 mg of Morphine (not known) 16 mg of Ativan (at 0025 hours) 8 mg of Ativan (at 0026 hours) Respondent McDougall went to two areas of the hospital to find

	the large quantity of medication that had been requested. Because she was a floating nurse, she had access privileges at multiple Pyxis machines.
6) 0030 hours (estimated)	Respondent McDougall arrived at OR a short time (approximately 5 minutes) after Stevens requested additional medication, and delivered the vials (100 mg Morphine and 40 mg Ativan) to Stevens. No order for the medications was written at that time.
7) 0035 hours (estimated)	**Administration of Medication** Stevens drew 50 mg Morphine and 20 mg Ativan into syringes – then administered it to Patient intravenously ("i.v.push"). Stevens observed no indications that Patient was in pain, anxious or having seizures, and that Patient was still breathing. Stevens heard Dr. Roozrokh express frustration, stating "This is why I don't like the D.C.D.'s (Donation after Cardiac Death)"
8) 0035-0040 hours (estimated)	**Administration of Medication** Roozrokh directed Stevens to administer the remaining medications. She did so, administering 50 mg Morphine and 20 mg Ativan to Patient intravenously ("i.v.push"). Stevens was not in a position to monitor vital signs, but observed that Patient continued to breathe on his own after this fourth administration of medication in the OR, 35 to 40 minutes after the breathing tube was removed.
9) 0045-0055 hours (estimated)	Carla Albright was on the telephone (in the OR) calling several people. Then Dr. Roozrokh took off his gloves and talked on the telephone for several minutes. Stevens was administering drugs while these conversations took place. Dr. Roozrokh then said "it's over" or "it's off." Stevens asked him what he wanted to do with the remainder of the Ativan she was injecting. He said he did not care. Stevens continued to administer the last cc or half of a cc it to Patient.
10) 0100 hours	Patient was then transferred from the OR back to ICU.

S. Before leaving the OR, Stevens asked Dr. Roozrokh to document the verbal order for medications. Dr. Roozrokh made notations in the chart which Stevens did not immediately review. She later observed that he had written "2/3/06, 12:50 a.m. in OR Morphine 50 mg IV and

Ativan 20 mg IV." - accounting for only half of what he had verbally directed her to obtain. At approximately 0215, Stevens wrote below Dr. Roozrokh's notation: "as verbal order 50 mg Morphine and 20 mg Ativan" and signed her name.

T. Stevens administered a total of 200 mg Morphine and 44 mg Ativan to Patient in the approximately 6 hour period between the start of her shift and Patient's return to ICU at approximately 0100 hours. Patient received no additional medication between his return to ICU and the end of Stevens' shift.

U. Patient was still breathing on his own when Stevens' shift ended at 0730 hours.

V. Patient did not expire until approximately 8 hours after extubation, and no organs were recovered for transplant.

W. Dr. Hooran Roozrokh was criminally prosecuted by San Luis Obispo County for acts alleged to have been undertaken to accelerate Patient's death during that 8 hours period, in order to recover organs for transplant. He was acquitted after jury trial.

X. On or about August 12, 2006, Stevens was questioned about giving medications without understanding the results, and stated that she did not need to know the effect of the medications on the patient. Further, when asked if she would have administered more medications, Stevens stated that she would have stopped giving medications when she ran out of medications.

Y. On or about June 7, 2006, Respondent McDougall stated that she was very uncomfortable with unusual amount of medication she was asked to take to the OR, but that she obtained and delivered the medication without questioning the orders.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

17. Respondent SUSAN MARIE MCDOUGALL is subject to disciplinary action under section 2761, subdivision (a)(1) on grounds of unprofessional conduct as defined in California Code of Regulations, Title 16, sections 1443 and 1443.5, in that Respondent, while on duty as a registered nurse during her normal working shift on or about February 3 and 4, 2006 at Sierra

Valley Regional Medical Center in San Luis Obispo, CA, was incompetent in providing nursing care for 26 year old Patient as follows:

A. Failed to meet standard(s) for competence performance set out in 16 C.C.R.§1443.5, in that she failed to question the unusual amounts of controlled medications she obtained and delivered for administration to Patient;

B. Failed to meet standard(s) for competent performance set out in 16 C.C.R. §1443.5(6) in that she failed to questions the unusual amounts of controlled substances she obtained and delivered for administration to Patient;

C. Failed to meet standard(s) for competent performance when she failed to report to the appropriate chain of command and/or reporting agencies the order to obtain and deliver for administration to Patient unusually high amounts of controlled substances. (Business and Profession Code §2725(4)).

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

18. Respondent SUSAN MARIE MCDOUGALL is subject to disciplinary action under section 2761, subdivision (a)(1) on grounds of unprofessional conduct as defined in California Code of Regulations, Title 16, section 1442, in that Respondent, while on duty as a registered nurse during her normal working shift on or about February 3 and 4, 2006 at Sierra Valley Regional Medical Center in San Luis Obispo, CA, was grossly negligent in providing nursing care for 26 year old Patient as follows:

A. By her own admission, Respondent was uncomfortable with the unusual amounts of controlled substances she was requested to obtain and deliver for administration to Patient. Respondent nevertheless failed to voice her concerns to her supervisor, the primary physician in the OR, or the ordering physician, or in any other way to question the unusual amounts of controlled substances she obtained and delivered for administration to Patient;

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B. Respondent obtained and delivered unusual amounts of controlled substances for administration to the patient without knowing or requesting information about Patient's medical history and/or condition.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

19. Respondent SUSAN MARIE MCDOUGALL is subject to disciplinary action under section 2761, subdivision (a) on grounds of unprofessional conduct, in that Respondent committed unprofessional conduct while on duty as a registered nurse during her normal working shift on or about February 3 and 4, 2006 at Sierra Valley Regional Medical Center in San Luis Obispo, CA, and assigned to provided nursing care for 26 year old Patient by reason of acts of incompetence and negligence described in paragraphs 17 and 18 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number RN 565591, issued to Susan Marie McDougall a.k.a. Susan Marie Michelbacher.

2. Ordering Susan Marie McDougall a.k.a. Susan Marie Michelbacher to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 7/20/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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